Registration/Medical Dental Form

Today's Date: _____

Patient's Name:_____ Birthday: _____

Address: _____ city-state:_____ Zip: _____
Social Security #:_____ circle: M or F Home Phone Number: _____

Marital Status: S M D W Spouse's Name:_____ Spouse's SS# _____

If Minor, Name and Address of Guardian: _____

Person Responsible for Fee: _____ Relationship to Patient: _____

Patient's Occupation: _____ Employer's Name: _____

Can You Accept calls at Work: circle: Y or N Work Phone Number: _____

Emergency Notification: _____
(nearest relative not living with you) Name/Telephone #

How did you hear about our office? _____

Insurance Information

	Primary Carrier	Secondary Carrier
Employer	_____	_____
Name of Ins. co.	_____	_____
Ins. co. Address	_____	_____
Ins. co. Telephone #	_____	_____
Group/Plan #	_____	_____
Insured's BirthdateSS#	_____ _____	Birthdate _____ SS# _____
Insured's Relationship to Patient	_____	Relationship _____

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Note: A change in your health status should be reported to the office at earliest possible time.

Please read and sign the following:
I understand that I am responsible for all costs of treatment. I hereby authorize payment directly to this dental office of the group insurance benefits. I agree what my insurance does not pay, I will pay in a timely manner. I understand that if a payment is delinquent, the account will be turned over to an outside collection agency and I will be responsible for additional collection costs. I hereby authorize this dental office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. This information on these pages is correct to the best of my knowledge.

_____

Signature Relationship to Patient

_____

INSTRUCTIONS:

To receive treatment in this office, you must answer all questions on this history form. The questions asked relate directly to the safe and effective treatment you are to receive in the office. To the best of your ability, honest answers must be given. All information you supply to the office, on this form, will be held in the strictest confidence, and will not be disclosed without your express and written permission.

1. Name, address & phone # of your physician: _____

2. Date of last visit to your physician:_____Purpose of visit: _____

3. Do you suffer from a disability? _____ If yes, describe:

4. Have you ever, or do you now take illegal drugs? _____ If yes, what drugs and when were they taken: **Note: *There* are drugs and medications *used* in routine dental care that are**

Incompatible with several illegal drugs. *The effect of* **the combination may be dangerous to your** *health.*

5. Do you have AIDS, or are you HIV-positive? _____**If** yes, describe and provide current status: ____

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6. Do you now have, or have you ever had venereal disease?_____

7. Have you ever had hepatitis? _____ If yes, describe: _____

8. For females: Are you pregnant? _____ If yes, when are you due? _____

9.For females: Are you taking birth control pills? _____ **Note: *There* are drugs and medications *used* in routine dental care that *decrease* the effectiveness of birth control pills.**

10. Are you taking any medications now?_____If yes, describe: _____

There are many *medication* incompatibilities, information about **your current use of medication is essential.**

11. Have you ever had an allergic reaction to medication? _____ If yes, describe: _____

12. Have you lost weight recently? _____ If yes, describe:

Have You Ever Had Or Been Treated For:

13. Rheumatic Fever, rheumatic heart disease, heart murmur or congenital heart disease? _____

If yes, describe: _____

14. Heart trouble, heart attack, angina, heart surgery, a pacemaker, or irregular beats? _____

If yes, describe: _____

15. Stomach or intestinal disease?_____

16. Abnormal blood pressure, excessive bleeding, or anemia? _____

17. Have you ever taken Fen-Phen for weight loss? _____

18. Have you had any replacement joints, implants, or breast implants? _____

19. Breathing problems or renal dialysis? _____

20. cancer, X-ray treatments, or chemotherapy?_____

21. Diabetes?_____ Insulin controlled? _____ Medication controlled: _____

22. Kidney problems or renal dialysis?_____

23. A stroke, convulsions; or fainting spells? _____

24. Tumors or growths? _____

25. Arthritis or rheumatism? _____

26. Have you ever had a major operation? _____ If yes, describe:_____

27. Have you injured your head or neck?_____ If yes, describe:

28. Are you on a special diet? If yes, for what reason? _____

29. Do you smoke? _____ If yes, describe type and quantity: _____

30. Have you consulted a psychiatrist, psychologist or counselor?_____ If yes, describe:_____

_____

31. Any other health problems? _____

DENTAL HISTORY:

Name of Previous Dentist: _____ Date of last visit:

Reason of last visit: _____Do you have your x-rays?_____

In respect to any previous dental treatment, have you:

32. Ever fainted? _____ If yes, please describe:_____

33. Had an allergic reaction or abnormal bleeding? _____

34. Any other complication during dental treatment? _____ If yes, describe: _____

35. Do your gums bleed on brushing or eating?_____ Does food catch between your teeth? _____

36. Have your teeth shifted, moved, flared or coming loose?_____

37. Are any teeth sensitive to heat, cold or pressure? _____

38. Do you grind your teeth or clench your jaws? _____Do any of your teeth ache?

39. Do you have pain or clicking in the jaw joint by your ear?_____

40. Are any of your jaw muscles sore? _____

41. Are there any growths in your mouth?_____

42. Do you have any other dental complaint? _____

This information on these pages is correct to the best of my knowledge.

_____

Signature